

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(C1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188628	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(C3) DATE SURVEY COMPLETED C 08/02/2012
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(C4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(C5) COMPLETION DATE
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<p>F 000</p> <p>F 225 SS=D</p>	<p>INITIAL COMMENTS</p> <p>An abbreviated survey investigating complaint KY#00018853 was conducted 07/31/12 through 08/02/12. KY#00018853 was substantiated with deficiencies cited.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	<p>F 000</p> <p>F 225</p> <p>F 225</p>	<p>Johnson Mathers Nursing Home acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Johnson Mathers Nursing Home's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor that any deficiency is accurate. Further, Johnson Mathers Nursing Home reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.</p> <p>On 7/31/2012, the Administrator received documentation from an LPN on a resident concern form that Residents # 2, 3 and 4 had stated they did not receive pain medication as documented as given by LPN#7 on the 3-11 shift of 7/29/2012. The Administrator had begun her investigation into the allegation on that day when the State Survey Team arrived in the building. Within a few hours, it was determined the State Survey Team was investigating the same allegation as the Administrator.</p>	<p>RECEIVED AUG 29 2012</p> <p>8/24/12</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Admin	(C6) DATE 8/24/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLSLE, KY 40311		
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F 225	<p>Continued From page 1 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure an allegations of misappropriation of property were reported to the administrator immediately in accordance with State and Federal regulations and the facility failed to provide evidence that the allegation was thoroughly investigated for six (6) of seven (7) sampled residents. Staff interviews revealed suspicion of misappropriation of narcotic medications, by a staff nurse, was reported to administrative staff, but the administrator was not made aware of these allegations and no investigation was conducted.</p> <p>The findings include:</p> <p>Review of the facility's policy: "Abuse, Neglect, or Misappropriation of Resident Property Policy", dated 02/2009, revealed any employee who witnesses or suspects that abuse, neglect, or misappropriation of property has occurred will immediately report the alleged incident to their supervisor, who will immediately report the incident to the Administrator. Failure to report any concern related to neglect, abuse, or misappropriation of property will result in disciplinary action and possible termination of employment. The Administrator is responsible to</p>	F 225	<p>LPI#7 was suspended August 1, 2012 pending the completion of the internal investigation by the Administrator then terminated 8/23/12.</p> <p>All residents have the potential to be affected. Group interviews were held by the Administrator with all staff at the mandatory in-services 8/9/12-8/10/12 and by the Staff Facilitator on 8/17/12 regarding other resident concerns and/or allegations of abuse, neglect or misappropriation of property the staff were aware of but had not reported to the Administrator. No additional allegations were reported.</p> <p>All staff were re-educated on 8/9/12, 8/10/12 & 8/17/12 by the Administrator and the Staff Facilitator regarding their responsibility to immediately report any allegation of abuse, neglect or misappropriation of property to the Administrator or the DON in her absence. Staff was educated that resident property includes medications, supplies or equipment provided by the</p>	8/25/12	

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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2228 CONCRETE ROAD CARLISLE, KY 40311
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F 225 Continued From page 2
ensure that complaints of abuse, neglect, or misappropriation of property and injuries of unknown origin will be investigated by the facility.

Interview, on 08/02/12 at 4:45 PM, with the Administrator revealed residents' medications were considered the residents' property. If staff had a concern someone was taking their medication they would have to follow the facility's abuse policy. Allegations should be reported immediately and investigated.

Review of Resident #1's medical record revealed the facility admitted Resident #1 on 08/30/08 with diagnoses which included Osteoporosis, Aridity, Muscle Weakness, Gout, Depression, Hypertension, Pathological Patella Fracture, and Chronic Obstructive Pulmonary Disease. Review of the July 2012 Medication Administration Record (MAR) revealed order for Tylenol ES (Extra Strength), 500 Milligrams (MG) tablet every six (6) hours as needed for pain or fever and Tylenol #3 (APAP/Codaine) 300/30 MG tablet every four (4) hours as needed for Right Knee Pain. Further review of the July 2012 MAR revealed Licensed Practical Nurse (LPN) #7 had documented giving ten (10) doses of Tylenol #3 with only 1 (one) dose given for complaint of knee pain. Additional review of June 2012 MAR revealed that LPN #7 had administered Tylenol #3 on 08/25/12, at 08:00 PM (2100), for complaint of headache.

Review of Resident #2's medical record revealed the facility admitted Resident #2 on 07/26/11 with diagnoses which included Anemia, Hypothyroidism, Hyperlipidemia, Dehydration, Prostate Cancer, Cancer Cachexia, Chronic

F 225 Nursing Home and charged to the resident as a part of their monthly bill. Also, on those dates staff was in-serviced on the appropriate use of the Resident Concern form used to report directly to the Administrator any resident, family, visitor and/or staff concern or allegation about resident care.

To ensure that all resident concerns and/or allegations are investigated thoroughly and reported to the appropriate agencies timely, the Administrator will maintain a log of all resident concerns/allegations that will include disposition of the concern/allegation. These will be reported monthly for the next three months then quarterly thereafter to the Quality Improvement Executive Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, QI Nurse and any other

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F 225	Continued From page 3 Bilateral Lung Edema, Arthritis, and Peripheral Edema. Review of the July 2012 MAR revealed Tylenol ES 500 MG, one (1) tablet every four (4) hours as needed for pain/temperature was given a total of ten (10) doses, with all doses documented as effective. LPN #7 did not give any Tylenol ES. Further review of the July 2012 MAR revealed Tylenol #3 (APAP/Codaine) 300/30 MG, one (1) tablet every four (4) hours as needed for pain, had twenty three (23) doses given with LPN #7 documenting giving twenty (20) of the doses. Review of Resident #3's medical record revealed the facility admitted Resident #3 on 11/16/10 with diagnoses which included Insomnia, Depression, Chronic Airway Obstruction, and Multiple Aspiration Pneumonia. The resident had a fall on 06/18/12 and was diagnosed with a Fracture of the Left Tibia. Review of the July 2012 MAR revealed orders for Motrin 800 MG every six (6) hours for pain and Lortab 10/325 MG as needed every four (4) hours for leg fracture pain. Further review of the July 2012 MAR revealed thirty-eight (38) doses of the Lortab was given, but after 07/18/12 LPN #7 gave all but one of the doses (a total of fourteen (14) doses, two doses each shift). Review of Resident #4's medical record revealed the facility admitted Resident #4 on 07/20/12 with diagnoses which included Unspecified Osteomyelitis Ankle and Foot, Morbid Obesity, Chronic Airway Obstruction and Sleep Apnea. Review of the Physician's orders revealed the resident had Tylenol 650 MG given every 6 hours as needed for pain and Percocet 5/325 MG given every six (6) hours as needed for pain. Review of the July 2012 MAR revealed only Percocet 5/325	F 225	persons required to provide information pertinent to the reports being presented and discussed at the Executive Committee meeting with further action taken as directed by the committee.		

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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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F 225	<p>Continued From page 4</p> <p>MG given, a total of fourteen (14) doses, and all but one dose given by LPN #7.</p> <p>Review of Resident #6 medical record revealed the facility admitted Resident #6 on 02/12/11 with diagnoses which included Insomnia, Anxiety, and Depression. Review of the July 2012 MAR revealed Fioricet BUT/APAP/CAF (contains barbiturate) tablet every four (4) hours as needed for headache. Further review of the MAR revealed LPN #7 gave all doses of this medication, a total of six (6) doses.</p> <p>Review of Resident #7 medical record revealed the facility admitted Resident #7 on 11/01/10 with diagnoses which include Osteoporosis, Atypical Psychosis, Constipation, Seizure Disorder, Peripheral Edema, and Dementia with Behaviors. Review of June 2012 MAR revealed orders for Tylenol 650 MG suppository per rectum every four (4) hours as needed for pain/temperature and Morphine Sulfate Injection 4 MG/ML (ML) with 1 ML given intramuscularly every six (6) hours as needed for pain. Further review of June 2012 MAR revealed LPN #7 administered all five (5) doses of Morphine Sulfate. Review of July 2012 MAR revealed an additional order for Tylenol 500 MG per oral (PO) every four (4) hours PRN pain. Further review of the July 2012 MAR revealed seven (7) doses of Tylenol 500 MG given and four (4) doses of the Morphine Sulfate were administered. LPN #7 documented administering all four (4) doses of the Morphine Sulfate.</p> <p>Interview, on 08/01/12 at 6:45 PM, with LPN #3 revealed Resident #1, #2, #3, and #4 do not complain of any pain on his/her shift. However, it</p>	F 225		
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F 225	<p>Continued From page 5</p> <p>appeared PRN narcotic pain medications were routinely given to these residents by LPN #7 during their shift. In some cases LPN #7 was the only nurse giving the medications. LPN #3 revealed he/she suspected LPN #7 may be taking the medications. LPN #3 reported asking Residents #2, #3, and #4 if they were getting the pain medications. Resident #2 (Tylenol #3 (APAP/Codaine) 300/30 MG tablet) and Resident #3 (Percocet medication for pain) reported no pain and did not get pain medications. Resident #4 (PRN Percocet medication for pain) said he/she did not take that stuff. LPN #3 stated she followed chain of command and took the concern to the Charge Nurse and was told it had reported, but did not identify to whom. Further interview revealed LPN #3 latter asked why wasn't something being done and was told they didn't know they just reported it. LPN #3 also stated the residents paid for the medication. It was stealing to take them. It could be misappropriation of property because the medications belonged to the residents.</p> <p>Interview, on 08/01/12 at 6:10 PM, with LPN #4 revealed she had concerns LPN #7 may have been taking the residents' pain medications. Resident #1 and #2 had not requested anything for pain in the last several months. Resident #3 got Motrin every six (6) hours and reported it took care of his/her pain. Resident #4 got a midnight Neurontin and had never requested pain medication. When LPN #7 worked the above mentioned residents would get narcotic pain medications and didn't get them any other shift. Resident #7 had an order for Tylenol and Morphine IM for pain. LPN #4 revealed he/she gave the resident Tylenol and it was effective;</p>	F 225		
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F 225	<p>Continued From page 6</p> <p>however, when LPN #7 worked the resident would get Morphine. Resident #6 had Tylenol and Fioricet ordered for headaches. LPN #7 documented he/she gave Fioricet. LPN #4 said she asked the resident what medication they got for the headaches and was told Tylenol. Further interview revealed she took her concern to LPN #8, a member of the facility's Administration Team, and was told the Director of Nursing stated there was nothing they could do unless they witnessed LPN #7 pocket the narcotics. LPN #4 stated she did not think to talk to the Administrator because she followed the chain of command. The LPN stated she just had a suspicion and did not think it of it as misappropriation of property since they did not witness it occurring.</p> <p>Interview, on 08/02/12 at 7:30 AM, with RN #1 revealed she noticed a particular nurse (LPN # 7) was giving a lot of PRN narcotic pain medications. Other nurses had addressed this with her and suspected the nurse may have taken them. RN #1 said she talked to one of the Administration Nurses about three (3) weeks ago about her concerns and was told they were aware of the situation. Another nurse had informed the DON and they were told they would have to have proof the nurse was taking residents' medications. In light of knowing it had been reported to the DON and being told they would need proof, the RN did not report it to anyone else. Further interview revealed medications were considered the residents' property and was aware of misappropriation of property being abuse. RN #1 further stated she felt like an investigation should have been done.</p>	F 225		
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F 225	<p>Continued From page 7</p> <p>Interview, on 08/02/12 at 10:15 AM, with the Assistant Director of Nursing (ADON), revealed the Director of Nursing was informed a couple of weeks ago of concerns about LPN #7 giving an excessive amount of pain medications. The Director of Nursing told her they was not going to accuse someone of taking narcotics without proof. The DON wanted someone to witness this. The ADON was not aware of any investigation having been done. Further interview revealed medications were the residents' property. This could be classified as being misappropriation of property, if it was suspected someone may be taking the meds.</p> <p>Interview, on 08/02/12 at 1:40 PM, with the DON revealed if staff had concerns about missing medication this would be misappropriation of property. It should be reported per their abuse policy and there would be an investigation if there was a report of missing medications. In her role as DON it would be her responsibility to investigate.</p> <p>Continued interview with the DON, on 08/02/12 at 4:10 PM, revealed the facility didn't really review the Medication Administration Records to see if residents were only getting pain medications on a certain shift or to see if a certain nurse was only giving the pain medications.</p> <p>Interview, on 08/02/12 at 4:45 PM, with the Administrator revealed they had gotten a note on the back of a MAR a little while ago showing where LPN #7 had made time change corrections to the back of the MAR and this was discussed with the nurse. On Monday, 08/01/12, there were rumors floating around that a Resident Concerns</p>	F 225		
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F 225 Continued From page 8
Form was floating around stating LPN #7 may be taking residents' medications. She was made aware of the night shift concerns about LPN #7 taking medications. Further interview revealed she was not aware any of the facility's Administration Team having been informed of this concern. She should have been made aware. Medications were considered residents' property and the facility would follow their abuse policy if staff felt there was a concern. If there was something that raised a red flag, it should have been reported immediately and if residents reported they did not get pain medication, it should have been investigated per the facility's policy.

F 329 SS-D 483.25(f) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.
Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these

F 225

F 329
F329
The order for Tylenol #3 for Resident #1 has been discontinued. The order for Tylenol #3 for Resident # 2 has been discontinued. The order for Tylenol 650 MG suppository for Resident #7 and the order for Morphine Sulfate injection for Resident #7 has been discontinued.
All residents have the potential to be affected. The Admin Nurse Team consisting of the DON, ADON, QJ Nurse, MDS Nurses and the Staff Facilitator reviewed all current physician orders for all residents through 8/23/12 to identify any unnecessary drugs including duplicate therapy. Orders were obtained to discontinue all medications identified as unnecessary drugs.

8/25/12

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F 329	<p>Continued From page 9 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and review of facility's policy, it was determined the facility failed to ensure residents did not receive unnecessary drugs for three (3) of seven (7) sampled residents (Residents #1, #2, and #7). Licensee Practical Nurse (LPN) administered Per Requested or Needed (PRN) controlled medication instead of administering PRN non-controlled medication that was documented to have been effective on previous complaints of pain.</p> <p>The findings include:</p> <p>Review of the facility's policy titled 'Pain Management Policy And Procedure', dated 01/28/08, revealed it was the policy of the facility for nursing to choose the appropriate analgesic(s) when more than one was ordered and to involve the resident in making the decisions regarding their pain management plan whenever possible.</p> <p>Interview with LPN #8, on 07/31/12 at 05:15 PM, revealed nurses should use their nursing judgment when administering PRN pain medications. LPN #8 stated she usually started with a lower dose of available non-narcotic medication then she would administer a higher dose or the narcotic medication if lower dose was ineffective in relieving the pain.</p>	F 329	<p>All Nursing staff were re-educated on 8/9/12, 8/10/12 & 8/17/12 by the Administrator and the Staff Facilitator regarding the definition of unnecessary drugs and how to appropriately complete and document pain assessments for residents able and unable to report pain. Additional education was provided 8/23/12 and 8/24/12 to all licensed nursing staff and KMAs regarding the Pain Management Policy and Procedure including the need to avoid duplication by discontinuing any PRN order when the physician must be contacted for an additional PRN order due to the fact the first medication ordered is not effective.</p> <p>To ensure the policies are followed and the education was effective, the Admin Nursing Team consisting of the DON, ADON, QI Nurse, MDS Nurses and the Staff Facilitator will review all new physician orders and nurses notes daily, Monday – Friday to identify any unnecessary medications. The</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 183028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2012
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 329 Continued From page 10

Interview with LPN #9, on 08/01/12 at 02:10 PM, revealed nursing should always assess the resident's pain level before administering any PRN pain medication. LPN #9 stated pain severity would help determine if a lower dose or non-narcotic PRN would be given or a higher dose or narcotic medication was needed. Also, the nurse should review the effectiveness of previous PRN medications given to the resident to determine the effectiveness.

Review of Resident #1's medical record revealed the facility admitted Resident #1 on 08/30/08 with diagnoses which include Osteoporosis, Anxiety, Muscle Weakness, Gout, Depression, Hypertension, Pathological Patella Fracture, and Chronic Obstructive Pulmonary Disease. Review of the July 2012 Medication Administration Record (MAR) revealed an order for Tylenol ES (Extra Strength), 500 Milligrams (MG) tablet by mouth every six (6) hours as needed for pain or fever. Also ordered, Tylenol #3 (APAP/Codaine) 300/30 MG tablet every four (4) hours as needed for Right Knee Pain. Review of the July 2012 MAR revealed 10 (ten) doses of Tylenol #3 were given by LPN #7 with only one (1) dose given for complaint of (c/o) knee pain, although specific knee was not documented. Additional review of the June 2012 MAR revealed LPN #7 had administered Tylenol #3 on 08/26/12, at 09:00 PM (2100), for complaint of headache.

Interview with Resident #1, on 08/01/12 at 02:35 PM, revealed he/she had not asked for any PRN pain medication for the last couple of months. Resident #1 stated he/she had requested "regular" Tylenol for a headache once and awhile

F 329

results of these reviews will be reported monthly for the next three months then quarterly thereafter to the Quality Improvement Executive Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, QI Nurse and any other persons required to provide information pertinent to the reports being presented and discussed at the Executive Committee meeting with further action taken as directed by the committee.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2012
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2223 CONCRETE ROAD CARLISLE, KY 40311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 329	<p>Continued From page 11</p> <p>In the past, Resident #1 stated he/she would not want to take "something with Codeine or any other narcotics in it". When interviewed about receiving PRN Tylenol #3, ten (10) different doses that month, Resident #1 denied requesting or receiving Tylenol #3.</p> <p>Review of Resident #2's medical record revealed the facility admitted Resident #2 on 07/25/11 with diagnoses which include Anemia, Hypothyroidism, Hyperlipidemia, Dehydration, Prostate Cancer, Cancer Cachexia, Chronic Bilateral Lung Edema, Arthritis, and Peripheral Edema. Review of the July 2012 MAR revealed an order for Tylenol ES 500 MG, one (1) tablet by mouth every four (4) hours as needed for pain or temperature. Additionally there was an order for Tylenol #3 300/30 MG, one (1) tablet by mouth every four (4) hours as needed for pain. Further review of the July 2012 MAR revealed Tylenol ES was given total of ten (10) doses with all doses documented as effective. LPN #7 did not document giving any Tylenol ES. Additional review of July 2012 MAR revealed Tylenol #3 was given a total of twenty-three (23) doses, with LPN #7 documenting giving twenty (20) doses out of twenty-three (23) doses of Tylenol #3.</p> <p>Interview with Resident #2, on 08/01/12 at 02:30 PM, revealed he/she very seldom received any PRN pain medication at any other times except bedtime. Resident #2 stated he/she usually would request "something for a headache at bedtime". Resident #2 stated he/she was given "a sleeping pill and regular Tylenol" at bedtime.</p> <p>Review of Resident #7 medical record revealed the facility admitted Resident #7 on 11/01/10 with</p>	F 329		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 199028	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2012
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 329	<p>Continued From page 12</p> <p>diagnoses which include Osteoporosis, Atypical Psychosis, Constipation, Seizure Disorder, Peripheral Edema, and Dementia with Behaviors. Review of the June 2012 MAR revealed an order for Tylenol 650 MG suppository per rectum every four (4) hours as needed for pain/temperature. Also ordered was Morphine Sulfate Injection 4 MG/5mL (ML) with 1 ML given intramuscularly every six (6) hours as needed for pain. Further review of the June 2012 MAR revealed Resident #7 did not receive Tylenol 650 MG during this month but LPN #7 administered five (5) doses of Morphine Sulfate. Review of the July 2012 MAR revealed an additional order for Tylenol 500 MG per oral (PO) every four (4) hours PRN for pain. Further review revealed no Tylenol suppository was given in July 2012. Seven (7) doses of Tylenol 500 MG were given, all but one (1) dose recorded as effective. Continued review revealed four (4) doses of Morphine Sulfate were administered. LPN #7 documented administering all four (4) doses and recording all as effective. Resident #7 was non-interviewable.</p> <p>Interview with LPN #7, on 08/02/12 at 02:30 PM, revealed he/she felt it was appropriate to ask a cognitively intact resident which pain medication he/she would prefer if he/she had more than one (1) PRN medication ordered for pain. LPN #7 further revealed it could be considered giving an excessive dose of medication if the resident wasn't given the choice for lower dose or non-narcotic PRN pain medication. LPN #7 admitted that neither Resident #1 nor Resident #2 was ever asked which PRN pain medication they preferred. LPN #7 revealed in regards to Resident #7 that he/she would ask Resident #7 if he/she wanted "a shot or a pill" and stated she</p>	F 329		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2012
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NAME OF PROVIDER OR SUPPLIER JOHNSON MATHERS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2323 CONCRETE ROAD CARLISLE, KY 40311
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F 329	Continued From page 13 was unaware of the current order for Tylenol 650 MG suppository available for Resident #7.	F 329		
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